PCGHealth & Human Services™

The Health Benefit Exchange and the Commercial Insurance Market

Nevada Department of Health and Human Services

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Agenda

- Welcome and Introductions
- Overview of the Nevada Market
- Individual Market Rules
- Small Group Market Rules
- Risk Mitigation Measures in the Affordable Care Act
- Role of the Exchange
- Key Issues for Nevada
- Questions/Open Discussion
- Wrap-up and Next Steps

Purpose of the Public Forums

- Gather input from the public on key issues pertaining to the establishment of a Health Benefit Exchange.
- Provide information to the public on the State's approach to planning, designing and developing an Exchange for Nevada.
- Today's focus is on how the Exchange will fit into Nevada's commercial market.
- Your input and insight will help frame the discussion and inform the decisions going forward.

Overview of the Nevada Market

- Approximately 1.52 million residents, or 56 percent of Nevadans, are covered by commercial insurance
- The vast majority (87.5%) of commercially covered lives are in large group plans (>50 employees/subscribers).

Group Size	Number of Lives (Estimates)	Percentage of Commercial Market
Large Group (self-insured)	948,949	62.4%
Large Group (fully insured)	381,014	25.1%
Small Group (2 – 50 EEs) Market	102,728	6.8%
Individual Market	87,309	3.2%
TOTAL	1,520,000	

Overview of the Nevada Market

- Roughly nine out of ten employees in Nevada work for an employer that offers health benefits, which is comparable to the US average.
- Almost all large employers (>100 employees) provide employer-sponsored insurance (ESI) to their employees.
- However, among small employers:
  - 60% of employers with 10 – 24 employees offer ESI; and
  - Approximately 30% of employers with less than 10 employees offer health benefits to their workers.

Overview of the Nevada Market

- Public programs (Medicaid, CHIP, Medicare, TriCare, VA, etc.) provide health coverage to approximately 602,500 residents.
- There are approximately 578,000 uninsured residents in Nevada, comprising roughly 22% of the population.
- Expansion of Medicaid eligibility in 2014 may add another 100,000 residents to the Medicaid program.
- Recent estimates indicate that as many as 200,000 individuals will be eligible for health insurance through the Silver State Health Insurance Exchange.

Overview of the Nevada Market

- Nevada's commercial insurance market is competitive:
  - Approximately 28 carriers sell policies in the individual market; and
  - Nineteen (19) insurers offer health plans in the small group market.
- No carrier covers more than 50% of either the small group or individual market
- Five carriers insure roughly 85% of the small group market.
- Five carriers cover approximately 80% of the individual market.

Changes Under the Affordable Care Act

- Health care reform will bring major changes to the way health insurance is priced and distributed, particularly in the individual and small group markets.
- Four major changes:
  - Rating Rules – factors used to develop premiums;
  - Guarantee Issue – requirement that insurers enroll all eligible applicants;
  - Individual Mandate – requirement that people obtain and maintain health insurance, if coverage is affordable; and
  - Essential Health Benefits – benefits package that must be covered by the health plan.

Individual Market Rules in Nevada (today)

- Current rating rules allow insurers to establish rates based on six main factors:
  - Age
  - Gender
  - Occupation
  - Residence (location)
  - Family composition (rate basis type)
  - Health status
- No requirement that policies be sold on a guarantee issue basis.
- All policies subject to Division of Insurance review and approval.

Individual Market Rules in Nevada (in 2014)

- Rating rules limited to five factors:
  - Age – maximum 3 – 1 rate band
  - Residence (location)
  - Family composition (rate basis type)
  - Tobacco usage
  - Wellness program participation
- All policies must be guarantee issue.
- Use of health status (i.e., medical underwriting) is prohibited.
- All policies subject to Division of Insurance review and approval.

Individual Market Rules in Nevada (in 2014)

- All products much cover “essential health benefits” :
  - Ambulatory services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Secretary of HHS to further define “essential health benefits.”

Individual Market Rules in Nevada (in 2014)

- Cost-sharing (e.g., co-pays, co-insurance, deductibles) maximums for all plans based on high deductible health plan limits.
  - CY 2010 HDHP limits:
    - $5,950 for single coverage
    - $11,900 for family coverage
- Preventive care must be covered without cost sharing and is exempt from any deductible.

Small Group Market Rules in Nevada (today)

- Current rating rules allow insurers to establish rates based on the following factors:
  - Group size
  - Age of members
  - Gender mix
  - Industry
  - Residence (location)
  - Family composition (rate basis type)
  - Employer's premium contribution
- Health status of the group also used to set premiums.
- Policies are guarantee issue/guarantee renewal.
- HMO policies subject to DOI review and approval.

Small Group Market Rules in Nevada (in 2014)

- Rating rules limited to five factors:
  - Age – maximum 3 – 1 rate band
  - Residence (location)
  - Family composition (rate basis type)
  - Tobacco usage – maximum 1.5 – 1 ratio
  - Wellness program participation
- Use of health status (i.e., medical underwriting) prohibited.
- Policies must include “essential health benefits” and out-of-pocket limits.
- Deductibles limited to $2,000 (single) and $4,000 (family).
- All policies subject to DOI review and approval.

Risk Mitigation Measures in the ACA

- Shift to modified community rating and guarantee issue bring potential for adverse selection.
- Residents with pre-existing conditions who may have been denied coverage previously, or who never applied, or were "rated up" – charged a higher premium – will now have access to coverage at the same price as "healthy" individuals.
  - Individuals covered by the Pre-Existing Condition Insurance Plan (PCIP) will be transitioned to the "new" individual market.
- Each carrier will establish one risk pool for individual market and one risk pool for small group market.

Risk Mitigation Measures in the ACA

- Three risk mitigation provisions are included in the Affordable Care Act:

1. Transitional Reinsurance
2. Risk Corridors
3. Risk Adjustment

Transitional Reinsurance

Purpose:

- Limit carriers' financial exposure associated with covering "high risk" individuals for first three years (2014 – 2016)

How It Works:

- State Establishes reinsurance program and designates entity to collect payments from all insurers and third party administrators operating in the State.
- Carriers in the individual market receive payments to cover a portion of the cost of insuring "high risk" individuals.

Risk Corridors

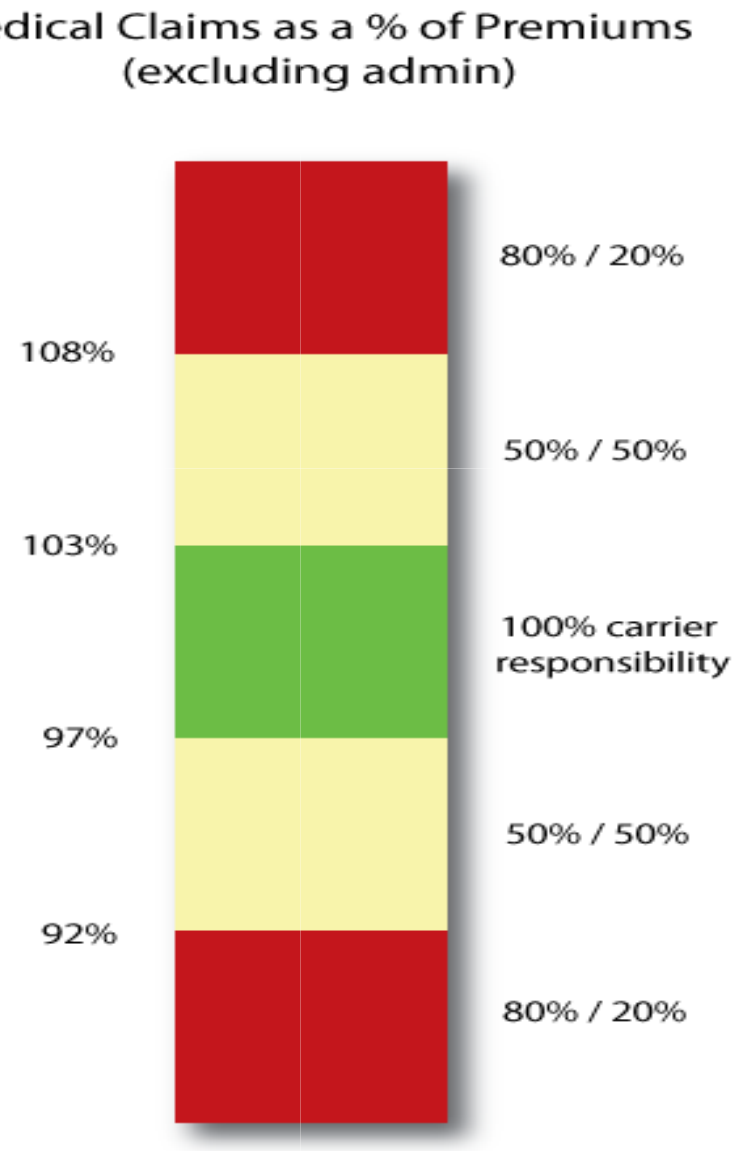
Purpose:

- Provide aggregate stop-loss coverage (i.e., insurance for insurers) for carriers in the individual and small group markets.

How it work:

- Carriers with aggregate claims that exceed 103% of premiums (excluding administrative costs) will have a portion of the excess costs covered by the risk corridor program; and
- Carriers with aggregate claims that are less than 97% of premiums (excluding administrative costs) will pay a portion of the excess premiums to the risk corridor program.

Risk Corridors



Risk Adjustment

Purpose:

- Mitigate the costs associated with adverse selection in the individual and small group markets.

How it works:

- Shifts funds from insurers in the individual and small group markets that enroll “more healthy” people to insurers that enroll “less healthy” people.

Role of the Exchange in the Commercial Market

- Distribution channel for individual and small group market.
- Certify that "qualified health plans" sold through the Exchange meet certain criteria, including, but not limited to:
  - Marketing standards
  - Network adequacy
  - Quality improvement programs
- Exchange must determine if offering the health plan – and continuing to offer the health plan – "is in the best interest of qualified individuals and qualified employers" in Nevada.
- Premium increases subject to review and approval by the Exchange, in consultation with the DOI.

Role of the Exchange in the Commercial Market

- Health plans offered through the Exchange must include essential health benefits and be offered in the five tiers based on actuarial value*:
  - Platinum (90% AV)
  - Gold (80% AV)
  - Silver (70% AV)
  - Bronze (60% AV)
  - Catastrophic (HDHP)

*Actuarial value is the percentage of medical claims covered by the plan's premiums vis-à-vis member cost-sharing.

Role of the Exchange in the Commercial Market

- Insurers must provide the Exchange, the DOI and the Secretary of HHS with certain information, including:
  - Claims payment policies and practices;
  - Periodic financial disclosures;
  - Enrollment and disenrollment data;
  - Claims denied data;
  - Rating practices;
  - Cost-sharing and payments pertaining to out-of-network coverage;
  - Enrollee and participant rights; and
  - Other information as required by the Secretary of HHS.

Key Issues for Nevada

- How will the new rating and underwriting requirements affect premiums for people currently insured in the individual and small group markets?
- What criteria should the Exchange use to certify qualified health plans?
- Within each coverage tier, how much variation in plan design (i.e., cost-sharing) should the Exchange allow?
- How can the Exchange best serve the small group market and enable small employers that currently don't offer ESI to contribute toward their employees' health benefits?

Key Issues for Nevada

- Should the Exchange establish minimum contribution and participation requirements for small employers purchasing coverage through the Exchange?
- Should small groups be limited to 50 or fewer employees until 2016, when the definition of small groups must be expanded to 100 or fewer employees?
- What role should the Silver State Exchange play in the Nevada insurance market?

Next Steps

- Upcoming public forums focused on:
  - Exchange overview (Elko, April 12)
  - The small business Exchange (April 26 and 27)
  - How the Exchange can align with the Medicaid and CHIP programs (May 24 and 25)
- Legislation establishing Silver State Health Insurance Exchange is in LCB
- Develop strategic plan and roadmap to establish an Exchange